Diabetes Health History Form and Management Planning Tool

The purpose of this form is to aid the school nurse in gathering the information necessary to develop the student's Individualized Health Plan and Emergency Action Plan.

Effective Dates: _____

Student's Name: _____

Date of Birth:_____ Known Allergies:_____

Grade:_____ Homeroom Teacher: _____

Diagnosis: ☐ diabetes type 1 ☐ diabetes type 2 Date of diabetes diagnosis: _____

Last hospitalization/ER visit for diabetes: _____ Has glucagon ever been administered? ☐Yes ☐No

CONTACT INFORMATION
Mother/Guardian: _____

Address:_____

Telephone: Home _____Work_____ Cell _____

Father/Guardian:_____

Address:_____

Telephone: Home _____ Work_____ Cell _____

Student's Doctor/Health Care Provider:

Name:_____

Address:_____

Telephone: _____ Emergency Number: _____

Preferred Hospital: _____

Other Emergency Contacts:
Name:_____

Relationship: _____

Telephone: Home_____Work _____Cell _____

Notify parents/guardian or emergency contact in the following situations:
_____

_____

Diabetes Health History Form and Management Planning Tool *(continued)*

BLOOD GLUCOSE MONITORING

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

Usual times to check blood glucose _____

Times to do extra blood glucose check (*check all that apply*)

- ☐ before exercise
- ☐ after exercise
- ☐ when student exhibits symptoms of hyperglycemia
- ☐ when student exhibits symptoms of hypoglycemia
- ☐ other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No
Exceptions: _____

Type of blood glucose meter student uses: _____

INSULIN

Type and dosage of insulin: _____ Timing: _____

Type and dosage of insulin: _____ Timing: _____

1. Can student give own injections? ☐ Yes ☐ No
2. Can student determine correct amount of insulin? ☐ Yes ☐ No
3. Can student draw correct dose of insulin? ☐ Yes ☐ No

FOR STUDENTS WITH INSULIN PUMPS

Type of pump: _____ Basal rates _____ 12 am to _____
_____ _____ to _____
_____ _____ to _____

Type of insulin in pump: _____ Type of infusion set_____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	***Needs Assistance***
Count carbohydrates	☐ Yes ☐ No
Correct bolus amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer corrective bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump at infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No

Diabetes Health History Form and Management Planning Tool *(continued)*

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Type and dosage of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Other medications: _____ Timing: _____

MEALS AND SNACKS EATEN AT SCHOOL

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	***Time***	***Carbohydrate servings/grams***
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

EXERCISE AND SPORTS

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below _____ mg/dl or above _____mg/dl or if moderate to large urine ketones are present.

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

Has glucagon ever been administered? ☐ Yes ☐ No

Diabetes Health History Form and Management Planning Tool *(continued)*

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

SUPPLIES TO BE KEPT AT SCHOOL

_____ Blood glucose meter, blood glucose test strips, batteries for meter
_____ Lancet device, lancets, gloves, etc.
_____ Urine ketone strips
_____ Insulin vials and syringes
_____ Insulin pump and supplies
_____ Insulin pen, pen needles, insulin cartridges
_____ Fast-acting source of glucose
_____ Carbohydrate containing snack
_____ Glucagon emergency kit

ACKNOWLEDGED AND REVIEWED WITH:

_____ _____
Student's Parent/Guardian Date

_____ _____
Student's Parent/Guardian Date

_____ _____
School Nurse Date